Battersea Bridge House

Quality Report

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Date of inspection visit: 19-21 April 2017
Date of publication: 14/07/2017

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Inadequate
Are services caring?	Requires improvement
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

We rated this service as **requires improvement** because:

- The hospital and the staff were experiencing a period of change with a new interim hospital director having been recently appointed. The hospital director was aware that a number of improvements were required in the service, though some work had not begun or been embedded at the time of inspection.
- At this current inspection, we identified that the provider had not addressed all the concerns that led to a rating of requires improvement for safe, following the previous inspection.
- Following our previous inspection, we issued a number of recommendations for the service to consider. At this current inspection, we identified that some improvements had not been made to ensure the recommendations were being met.
- During this inspection, we found that the management of medicines was not safe. Physical health checks and observations were not being routinely completed for patients on high dose antipsychotic medicines. Medicines were not always stored safely and staff did not assess and monitor patients for physical health side effects from clozapine treatment. In May 2017 we served the provider with a warning notice relating to these concerns.
- Staff did not follow up on patients' identified physical health concerns following assessments and physical health observations.
- Staffing levels were not always sufficient to meet the needs of patients. The provider had shifts that did not meet minimum staffing requirements and a qualified nurse was not always present in the communal areas. Some patients we spoke with said that they did not meet with their named nurse regularly.
- Staff did not undertake and document appropriate reviews of patients who were subject to the restrictions of seclusion.
- Staff did not always consider the specific communication needs of patients who had borderline learning disabilities or communication difficulties and include these in care planning.
- Emergency medicines were not easily accessible to staff on Browning and Hardy wards.
- Patients were unable to close observation panels on bedroom doors.
- Staff were not receiving regular clinical supervision.
- There were ineffective systems to robustly govern and monitor the performance and safety of the provider. The provider's complaints log had no evidence of investigations or outcomes of complaints. The system for recording incidents was not effective.

However:

- At the current inspection, the provider had improved in some areas where recommendations were given at our previous inspection. This included record keeping, regular access to the self-catering kitchen, appropriate physical health observations after rapid tranquilisation and ensuring the hospital director had sufficient authority to carry out their role.
- Staff were caring and respectful to patients and overall patient feedback was positive.
- Patients had good access to psychological treatment including groups and individual sessions.
- Patients had access to a large number of varied activities throughout the week to support them to develop skills to promote their future independence.
- Staff were happy with their work life balance and felt morale had improved.

Summary of findings

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Services we looked at:
Forensic inpatient/secure wards;

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Background to Battersea Bridge House

Battersea Bridge House is a location operated by Inmind Healthcare Group, an independent provider of mental health and social care services. Battersea Bridge House provides a low secure inpatient forensic services to men aged 18 and over with severe mental illness and additional complex behaviour. The service has 22 beds across three wards. Browning ward is an admission ward and has 10 beds. Hardy ward is a step down ward and has six beds. Blake ward is a pre discharge ward and has six beds. Twenty one of the 22 beds were occupied during our inspection. All 21 patients receiving care and treatment at the time of our inspection were detained under the Mental Health Act.

The service is registered to provide the following regulated activities:

• Assessment or medical treatment for persons detained under the Mental Health Act 1983

• Diagnostic and screening procedures

• Treatment of disease, disorder or injury.

Battersea Bridge House has been registered with the CQC since December 2010. There have been four inspections. We previously inspected Battersea Bridge House in July 2015 when we rated the service as 'good' overall. Following the inspection in July 2015, we rated safe as 'requires improvement' and effective, caring, responsive and well-led as 'good'.

Our inspection team

The team that inspected the service comprised five CQC inspectors and an inspection manager. The team also included two specialist advisors: a consultant psychiatrist in mental health forensic services and a mental health nurse.

Why we carried out this inspection

We undertook this unannounced inspection of Battersea Bridge House on 19 – 21 April 2017 as part of our on-going comprehensive mental health inspection programme.

Following the previous inspection in July 2015, we told the provider it must take the following actions to improve its services:

- The provider must complete work to remove ligature risks and deal with other environmental concerns, including the hospital's plumbing and water systems.

Following the previous inspection in July 2015 we also told the provider that it should consider taking the following action:

- The provider should ensure that staff record regular observations for each patient during each episode they are nursed in seclusion.
- The provider should ensure that staff complete and record appropriate physical health observations when a patient is given rapid tranquilisation.
- The provider should ensure that staff keep for each patient accurate records of their status under the Mental Health Act, their personal details and the medicines being prescribed.
- The provider should ensure that structures are developed and implemented to share learning about incidents across different hospital sites. When an incident occurs, staff should be supported to de brief.

Summary of this inspection

- The provider should ensure that patients are involved in the development and review of their care plan and where this is not possible, the reasons for this should be recorded.
- The provider should ensure that where patients have not understood their rights under the MHA this is revisited with them in a timely manner.
- The provider should ensure that information about its complaints procedure is displayed around the hospital and that all complaint investigation records are stored together in the format prescribed by their complaints policy and procedure.
- The provider should ensure that patients are able to access the self-catering kitchen regularly in order that self-care skills can be practised and developed prior to discharge.
- The provider should ensure patients privacy is protected when accessing the hospitals garden and that consideration is given to making the garden a pleasant environment for patients.
- The provider should ensure that appropriate arrangements are in place for patients to access funds from their bank account when they do not have leave in place.
- The provider should ensure that senior managers at a corporate level have a presence within the hospital and understand the demands of providing care and treatment.
- The provider should ensure that the hospital manager has sufficient authority to carry out their role, including management of a local budget for maintenance and improvement of the environment in a timely manner.

At the previous inspection we issued the provider with requirement notices. These related to the following regulation under the Health and Social Care Act (Regulated Activities) 2014:

Regulation 15 Safety and suitability of premises

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about Battersea Bridge House.

During the inspection visit, the inspection team:

- visited all three wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 11 patients who were using the service
- spoke with the interim hospital director, group operations director and director of quality;
- spoke with 15 other staff members; including a doctor, nurses, an occupational therapist, a psychologist and a social worker
- looked at 15 care and treatment records of patients
- carried out a specific check of the medicines management across all three wards; and
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

We spoke with 11 patients over the course of the inspection. The majority of patients felt staff were respectful and polite and felt safe in the hospital. Patients felt that staff were visible on the wards. However, some felt they did not have opportunities to meet with their named nurses due to the system of staff working across all wards. Some patients did not feel confident about the support they received for their physical health and two patients said their beds were uncomfortable. Patients told us that they enjoyed the meals at the service, which were of good quality with appropriate portions.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as **requires improvement** because:

- Medicines were not always stored safely. Staff had not always recorded checks of fridge temperatures and did not ensure it was safe to use.
- Emergency medicines were not easily accessible to staff.
- At the previous inspection work had not been completed to remove ligature risks and deal with other environmental concerns. At this current inspection, we identified this had partially improved. The provider had begun work on anti-ligature fixtures in patients' bedrooms. However, the work was on going with further work to reduce the number of ligature anchor points scheduled to be completed by August 2017.
- At the previous inspection, staff did not record regular observations of patients in seclusion. At this current inspection, we identified that this had not improved. Seclusion records showed staff had not always recorded medical reviews, nursing reviews and multi-disciplinary reviews.
- At the previous inspection, structures were not developed and implemented to share learning about incidents across different hospital sites and when an incident occurred staff were not supported to debrief. At this current inspection, we identified that this still needed to be improved. Procedures to report incidents were complex and there was no active learning from adverse incidents or improvements that were made within the service or across other locations.
- There were not always sufficient staff on duty to ensure the safety of patients. We identified that on many occasions, staffing levels were below the provider's minimum requirements. Staff said wards were sometimes short of staff and patients said qualified nurses were not visible on the wards throughout the day. Patients were not always able to meet for 1:1 meetings with their named nurse.
- Patients were unable to close viewing panels on their bedroom doors.
- At the previous inspection, the service had a number of maintenance issues that included the malfunction of the

Summary of this inspection

airlock and manual door locks jamming. At this current inspection, we identified that this had not improved. The airlock did not work properly. However the provider had fixed this on many occasions.

- Staff did not always update risk assessments following incidents.
- The service had a clear and up to date safeguarding register. However staff were not actively monitoring safeguarding referrals.

However:

- At the previous inspection, staff did not complete and record appropriate physical health observations when a patient was given rapid tranquilisation. At this current inspection, we identified that this had improved. Staff had completed appropriate physical health observations.
- At the previous inspection, regular environmental audits had identified a number of issues and the service required building works to address these. At this current inspection, this had improved. After a review by an external organisation, the service monitored and addressed this presence of bacteria, and flushed taps regularly.
- Agency staff use was not high and the hospital used regular agency staff to promote continuity of care.

Are services effective?

Inadequate

We rated effective as **inadequate** because:

- Staff did not adequately monitor physical health or take effective action to address physical health needs for patients prescribed medicine higher than the recommended dose.
- Staff did not proactively assess and monitor potential side effects of clozapine treatment including constipation.
- Staff did not take effective action to meet patients physical health needs. Although staff undertook observations of patients' physical health they did not always follow up on identified concerns.
- Staff were not receiving regular supervision in line with the provider's supervision policy.
- Staff administered medication for a patient detained under the Mental Health Act (MHA) without a valid consent to treatment authorisation.
- The care plans of patients on the pre discharge ward lacked a recovery focus or goals to prepare patients for discharge back in to the community.

Summary of this inspection

- Staff did not always explain patients' rights to appeal against detention under section 132 MHA for patients who required easy read formats of information or required translation into another language.

However:

- At the previous inspection, the provider did not keep accurate records of patients' status under the Mental Health Act, their personal details and the medicines being prescribed. At this current inspection, we identified that this had improved.
- At the previous inspection, staff did not explain patients' rights under the Mental Health Act in a timely manner. At this current inspection, we identified that this had improved. Staff regularly explained Section 132 rights to most patients and logged when they gave patients this information.
- Patients had access to individual and group psychology sessions on a regular basis. Flexible and creative approaches were adopted to engage patients in psychological therapies.
- The MDT supported patients to develop personal goals in discharge planning through role play of discharge planning meetings.
- Staff participated in a number of clinical audits across the ward and improvements were made to the service.
- A strong multi-disciplinary team worked across the hospital providing a multi-disciplinary approach to assessment and care planning.

Are services caring?

Requires improvement

We rated caring as **requires improvement** because:

- At the previous inspection, staff did not involve patients in the development and review of their care plans or record the reasons why this was not possible. At this current inspection, we identified that this had not improved. The majority of the care plans we reviewed had minimal patient involvement despite staff recording that the patients were involved.
- Some patients raised issues regarding having the opportunity to meet with their named nurses and concerns around support for their physical health.

However:

- The majority of patients we spoke with felt safe and that staff were respectful and polite.

Summary of this inspection

- Staff provided care to patients in a responsive and interested manner.
- Patients we spoke with felt the activity timetable was good.
- The service had a regular community meeting for patients with a set agenda that discussed items such as catering, maintenance and activities.

Are services responsive?

Requires improvement

We rated responsive as **requires improvement** because:

- The provider's complaints log had no evidence of investigations or outcomes of complaints.
- Staff had not met the communication needs of some patients. The service had not appointed an interpreter for a patient who spoke little English and used an unqualified member of staff to translate. For two patients identified as possibly having borderline learning disabilities, staff had not identified specific needs relating to communication.
- At the previous inspection, appropriate arrangements were not in place for patients to access funds from their bank account when they did not have leave in place. At this current inspection, we identified that this had not improved. The system for managing finances for patients who were not able to leave remained unclear.
- Information leaflets were not available in languages other than English and there were no information resources for patients with different language needs. At the time of the inspection there was one patient who did not speak English.
- Patients did not have access to a multi-faith room. Staff did not support patients with their cultural and spiritual needs.

However:

- At the previous inspection, patients were unable to access the self-catering kitchen regularly in order that independent living skills could be practised and developed prior to discharge. At this current inspection, we identified that this had improved. Patients had access to facilities to develop their skills and to the kitchen under supervision from the occupational therapist.
- The service had a full range of rooms and equipment to support treatment and care. Each ward had a communal lounge and dining area.
- The MDT team ran a full programme of therapy and groups during the day and patients on the ward had access to a large range of activities including cooking sessions, Tai chi and mindfulness.

Summary of this inspection

Are services well-led?

Requires improvement 

We rated well-led as **requires improvement** because:

- The hospital did not have embedded or effective governance systems to monitor the performance, safety and quality of the service. Senior directors had limited insight in to how the hospital collated information and were unaware of how trends were analysed or disseminated throughout the organisation. For example directors did not know the themes from complaints and how the hospital was addressing these concerns.
- At the previous inspection, this had partially improved. The majority of staff were aware of who senior managers were within the provider. However most staff did not feel they were visible on the wards despite visiting the service.

However:

- At the previous inspection, the hospital manager did not have sufficient authority to carry out their role, including management of a local budget for maintenance and improvement of the environment in a timely manner. At this current inspection, we identified that this had improved. The interim hospital director had control of the budget for maintenance and improvement of the environment was on-going.
- Staff felt morale had improved in the three months prior to the inspection.
- Staff felt they had a good work life balance.

Detailed findings from this inspection

Mental Health Act responsibilities

- The service had a Mental Health Act office and a Mental Health Act administrator who reviewed Mental Health Act documentation. The Mental Health Act administrator completed audits of patient Mental Health Act documentation and kept the results of the audits in patient care records.
- Staff had attached forms, which document each patient's consent to treatment, to patients' drug charts. Staff completed capacity to consent to care and treatment forms where appropriate.
- Patients had access to an independent Mental Health Act advocate who visited the service once a month. The service displayed posters in communal areas of the advocates contact details. Patients said they knew who the advocate was and received support from them.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated an understanding of the principles of the Mental Capacity Act. We looked at patient's records and staff had recorded assessments of capacity appropriately. Staff had made an assumption of capacity for patients.

Requires improvement

Forensic inpatient/secure wards

Safe	Requires improvement
Effective	Inadequate
Caring	Requires improvement
Responsive	Requires improvement
Well-led	Requires improvement

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

- The hospital had three wards located across different floors in a four storey building. All three wards had blind spots that prevented staff from being able to observe patients in all areas. For example, staff in nursing offices did not have a clear sightline of corridors or patient's payphones, which the service had situated in a recess. However, to mitigate this, staff knew the patients well, used regular observation of patients and individual risk assessments to determine the frequency of observations required. Patients assessed as a higher risk were on one to one observations in line with their care plans. The wards also had closed circuit television (CCTV) that sent images to the hospitals administration office.
- The service conducted an annual ligature risk assessment to identify ligature anchor points across the wards, which was most recently updated in March 2017. At the previous inspection, we found that the services' ligature risk assessment identified a range of ligature points throughout the hospital that required replacement without an established timescale. At this current inspection, we identified that the provider had begun to make the required improvements and had a timescale for the work to be completed. The provider had begun works to fit anti-ligature fixtures in patient's bedrooms and had completed this for eight bedrooms. Works for 14 bedrooms were on-going and still due to have works completed. The service's action plan stated that all works were due for completion by August 2017.
- All wards had a clinic room. The clinic rooms were clean, neat and tidy. Whilst the clinic rooms on Browning and Hardy wards were small and did not have examination couches, they were sufficient to meet the needs of the wards. Staff we spoke with across all three wards knew the locations of ligature cutters, which were visible in staff areas.
- Medicines fridges were in working order and we observed that an external pharmacist audited medication. The service used the fridge on Blake ward to store medicine. This meant that in an emergency, where a patient required the use of emergency medicines, staff on Browning and Hardy wards would need to go to Blake ward which was on a different level in the building. This was a risk as there would be a delay in responding to an emergency where patients needed emergency medicine.
- The resuscitation equipment for the service was located on Blake ward. The clinic room on Blake ward had a defibrillator that staff had last checked in January 2017. This was the sole defibrillator in the hospital for all three wards. Therefore, in an emergency, staff on Browning and Hardy wards would need to go to Blake ward which was on a different level in the building. As the wards were on different floors, separated by doors and staircases, there was a risk of a delay in staff accessing the equipment promptly when responding to a cardiac arrest emergency where basic life support may need to be administered. We discussed this with the hospital director immediately during the inspection, and actions were taken to ensure safe access to resuscitation equipment was made available to all three wards following the inspection.

Requires improvement

Forensic inpatient/secure wards

- The hospital had one seclusion room. The seclusion room had toilet facilities, a clock and allowed two-way communication.
- All wards we visited were visibly clean, had modern furnishings and were well-maintained. The service had domestic staff on the premises daily who cleaned the environment regularly and kitchen staff carried out regular cleaning in kitchen areas. We looked at the cleaning records for this and observed that kitchen staff carried out deep cleans each week. Signs and posters that promoted handwashing were visible in all bathroom and kitchen areas. The service completed an annual infection control audit to ensure the environment was compliant with infection control standards and principles. This was last completed in November 2016.
- At the previous inspection, we identified that regular environmental audits had identified a number of issues that needed to be addressed. At this current inspection, we found that an external organisation carried out monthly checks of bacteria in the service's water system. This review found some growth of legionella though the strain of legionella was not harmful to staff or patients. To monitor and address this presence of bacteria, the service flushed taps regularly.
- The service undertook health and safety checks of the building. At the previous inspection, we identified that regular environmental audits had identified a number of maintenance issues. This included the malfunction of the airlock and manual door locks jamming. At this current inspection, we identified through daily health and safety checks of the building for the last two weeks that the airlock door was not working. The airlock door would be fixed for a few days then break again a few days later. Staff told us that maintenance had fixed the door the week before our inspection. However during the inspection the door broke again and the interim hospital director informed us that maintenance staff were coming to fix it within the next few days. Staff explained that the airlock was an on-going issue where the door would be fixed and then break again a few days later. This potentially meant that members of the public could enter the building when it was unlocked and patients' could leave the premises when in the reception area. The service mitigated this by ensuring patients were not allowed in the reception area unless they had leave.
- The service issued all staff with a personal alarm at the hospitals entrance. Staff completed daily checks of the staff panic alarms and security radios to ensure they were working.

Safe staffing

- The hospital had a staffing establishment of 11 whole time equivalent (WTE) nurses and 20 WTE healthcare support workers. At the time of our inspection there were four vacancies for nurses which was a 36% vacancy rate of qualified nurses and four vacancies for healthcare support workers which was a 20% vacancy rate
- The provider operated two shifts across the 24 hours and there were a minimum of nine members of staff on duty during day shifts, which included at least three registered nurses across the three wards. At night, there was a minimum of six members of staff with at least two registered nurses across the hospital. For the day shift, the clinical nurse manager allocated two of the registered nurses to Browning ward but each nurse spent part of the shift on the other wards to ensure a registered nurse was on each ward. The clinical nurse manager allocated staff to wards at the beginning of a shift. This meant that the shift coordinator could flexibly move staff around the hospital to ensure patients had access to allocated leave and that staff could take their planned breaks.
- Each shift had a shift leader who would be a qualified nurse. Staff worked across the three wards. Staff worked long days so the shift pattern was from 7.45am until 8pm and from 7.45pm until 7am. We reviewed staff rotas and daily allocation logs between 17 February 2017 and 17 April 2017. We found that on 15 days, the staff allocation for a day shift had been below 7 members of staff on duty. We found that on 26 days, there had been two nurses on duty instead of the minimum of three.
- Staff we spoke with felt that wards were sometimes short of staff. However, they also felt that managers were supportive and tried to ensure all shifts were covered. The provider had a pool of bank workers to cover additional shifts and also asked regular staff to do extra shifts. This ensured continuity of care for patients. If there were no regular staff to do extra shifts, the provider would procure staff from agencies. For January 2017, the provider used bank staff for 11% of shifts with

no agency use. For February 2017, the provider used bank staff for 13% of shifts with 1% of shifts requiring agency staff. For March 2017 bank staff covered 11% of shifts with 2% requiring agency staff.

- On both Blake and Hardy wards we observed that there was not always a qualified nurse present in communal areas. For example, on the first day of our inspection there was only one support worker on Blake ward during the afternoon while the qualified nurse was on their planned break. The support worker was also supporting a patient with 15 minute observations. Whilst there were three qualified nurses across the three wards, the service did not expect them to stay on a particular ward during the shift and nurses would go where there was an identified patient need.
- Patients had assigned key workers and associate nurses. However, the majority of patients we spoke with were unaware of their named nurse. We looked at the rota of keyworkers and associate nurses for five patients on Hardy ward. For all five patients, the keyworkers were working on the night shift for the week of our inspection. For the five patients, three of their associate nurses were working on the night shift, one was on leave, and one was assigned to another ward. This meant that these five patients did not have access to either their key worker or their associate nurse during the daytime for the week we inspected. We spoke to a staff member who was the associate nurse for four patients at the service. They said that they had not had a one to one with these four patients during the past four months.
- Both patients and staff we spoke with told us that the service rarely cancelled escorted leave and activities.
- During the day, there was a consultant psychiatrist available, giving adequate medical cover. The consultant was on call at night and during weekends and would go into the hospital as required.
- A range of mandatory training was provided. This included moving and handling, safeguarding, the management of violence and aggression, the Mental Health Act, the Mental Capacity Act, first aid, breakaway, medicines management, rapid tranquilisation, relational security, infection control, health and safety and information governance. The service had exceeded the target of 80% for completion for mandatory training.

Assessing and managing risk to patients and staff

- Staff undertook a risk assessment of patients on admission to the ward using a recognised tool to assess patient risk. We reviewed 15 risk assessments during our inspection. The risk assessments contained a patients risk history and a description of their current risks. The risk assessments included detailed narratives of a risk management plan and the likelihood of the risk re-occurring. The patients contributed to the risk assessments and gave their views on their current risk presentation. However, for one patient on Browning ward we saw inconsistencies between their risk assessment and care planning documentation. Additionally, on Blake ward, staff had not updated a patient's risk assessment following multiple incidents and another patient the service had admitted in February 2017, did not have a risk assessment in place.
- The provider had a blanket restriction of searching patients when they returned from unescorted leave which is an expected standard practice for low secure forensic services. This search consisted of a consented pat down search of the patient as well as a search of their personal belongings. The provider also searched patients' rooms when there were concerns that patients were keeping smoking materials. There was a room on the ground floor where staff could search patients which ensured that they maintained patient's privacy.
- Staff completed observation sheets on a regular basis and had a good understanding of the providers observation policy. However, staff left viewing panels in patients' bedroom doors continuously open and patients were not able to close these. When we spoke with staff about this, they informed us that patients could request that observation windows be closed but that for some patients they kept the viewing panels open due to patients smoking in bedrooms. This was not an appropriate or proactive measure to mitigate the risk of patients smoking in bedrooms.
- Through our discussions with staff, we observed that there had been a change in the hospital attitude to blanket restrictions and restrictive practices over the previous three months. The hospital was carrying out work specifically to reduce restrictive practice and promote greater leave for patients. Staff we spoke with said that this had a positive impact on patient care.
- Between October 2016 and April 2017 there were three incidents that required the use of restraint. Two of these incidents required the use of restraint in the prone

position and one resulted in rapid tranquilisation. Staff were trained in the Prevention and Management of Violence (PMVA) with the exception of one member of staff. However there was an appropriate number of staff trained in restraint on wards at all times to ensure this was not a risk.

- At the previous inspection, we identified that the provider should ensure that staff complete and record appropriate physical health observations when staff used rapid tranquilisation. At this current inspection we reviewed observation charts for patients administered rapid tranquilisation and saw that staff had completed the appropriate physical health observations and this had improved.

- At the previous inspection , we identified that the provider should ensure staff record regular observations for each patient during each episode they are nursed in seclusion. Between October 2016 and April 2017, there were six incidents that required the use of seclusion for patients. At this current inspection, we reviewed three seclusion records. On the first record, we saw that the service had secluded a patient overnight for a period of 13.5 hours with no medical review recorded or undertaken by staff. On the second record we discovered that an assistant psychologist had entered an observation record in the space where a nursing review should have taken place. On the third record we checked, we saw that a patient had been secluded for 23 hours and while medical and nursing reviews had taken place and been recorded, there was no indication that a multidisciplinary review had been undertaken by at least two qualified professionals. This meant that there continued to be a risk that staff did not undertake the appropriate checks when patients were subject to the restrictions of seclusion and that staff were not comprehensively completing seclusion records to ensure patients' safety.
- Staff displayed a good understanding of safeguarding and were trained in safeguarding adults from abuse. We spoke with five staff members about when and how they would raise a safeguarding concern. The staff members would raise a safeguarding concern if there was a threat which put the safety of a patient at risk, either physically, emotionally or financially. Staff were able to give examples of when a safeguarding referral was required, for example if a patient assaulted another patient. The hospitals safeguarding policy required staff to report all allegations or suspicions of abuse to the hospital director and social worker. Staff were aware of how to escalate a safeguarding concern through the provider's protocol.
- The service's safeguarding register was up to date and clear. The register included patients at risk of harm, persons causing harm, the suspected type of abuse, date of abuse, date alerted to the local authority in addition to any police involvement. However staff did not follow up safeguarding referrals on the register to clearly track at what stage the investigation into the concern had reached.
- Medicines were stored securely in the clinic rooms and were within their expiry date. An external pharmacist visited the provider and conducted weekly audits of medicine. The provider's medicines management policy stated that staff should record fridge temperatures daily, to monitor that medicine is stored at the correct temperature for safe administration. We observed gaps in the fridge temperature records, during our review of the records from January to April 2017. There were two days where staff had not recorded checks in January 2017 and three days in April 2017. We also observed during our inspection, that staff had left the fridge door open. The service used the fridge to store Lorazepam which is administered via intramuscular injection. This form of medication must be stored at a stable refrigerated temperature to ensure it is safe and does not degrade.

- All patients were prescribed a blanket prescription of liquid paracetamol to be administered as and when required. When we asked staff about this, they told us it was due to a risk relating to one patient on Hardy ward of hoarding paracetamol tablets. Staff were not able to demonstrate that they had offered options to patients and that the risk relating to one patient had been managed appropriately as all patients were subject to this decision. After completing the inspection, we fed this back to the responsible clinician who agreed to make a change in this practice and review this blanket prescription.

Track record on safety

- One serious incident had occurred in the year prior to the inspection. At the time of our inspection, the investigation for this incident was still underway.

Requires improvement

Forensic inpatient/secure wards

- Between 27 October 2016 and 18 April 2017, staff recorded 44 incidents at the service in the incident record book. Eight of these incidents involved patients physically assaulting another patient.

Reporting incidents and learning from when things go wrong

- Staff we spoke with were aware of what needed to be reported as an incident. Staff recorded incidents in four documents, the patients' progress notes, the ward's risk log, handover notes and the incident record book for the service. Staff recorded incidents in the patients' notes to keep a contemporaneous account of the patients' care and in the ward risk log to give staff an idea of the risks around patients on each ward. Staff recorded incidents in handover notes in order to give staff coming onto the ward a current understanding of the level of risk on the ward. They recorded incidents in the incident record book to centrally gather all the information about incidents for the service and to flag when incidents need investigation and escalation. However this was not an effective and cohesive system of recording incidents. In the incident record book, between 27 October 2016 and 18 April 2017, six of these records were blank except for the date of the incident and patient names. 30 of the incidents were not reflected in the ward risk log. This meant that staff on wards did not have easily available information of the risk level on the ward, which was important if there were agency staff or permanent staff who had been on leave. In 40 of the 44 records, the incident record did not state which ward the patient was located on or where the incident occurred. This meant it was difficult to draw any themes from where in the hospital the most incidents were happening.
- Staff were open and transparent with patients when things went wrong. There was a 'Duty of Candour' section of the incident record. This indicated that staff should prepare a letter of apology to the patient or their family. We saw an example of when the provider had contacted a patient's family in regards to an incident that had occurred in June 2016.
- At the previous inspection, we identified that the provider should ensure that structures are developed and implemented to share learning about incidents across different hospital sites and when an incident occurs, staff should be supported to de brief. At this current inspection we identified that the provider supported staff with a debrief after incidents to discuss what happened and how staff could have handled the incident better. However, we did not see evidence that the provider gave feedback from incidents both internal and external to the service to staff. We reviewed staff team meeting minutes for the previous four months leading up to the inspection. Whilst the team meeting minutes showed that some discussions had taken place regarding procedures to report incidents, incidents themselves and learning from incidents were not discussed at regular team meetings.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Inadequate

Assessment of needs and planning of care

- We reviewed the care records of 15 patients across all three wards. Staff completed a comprehensive mental health assessment of patients upon admission to the service. This included a physical health screening, the background personal history of the patient and a full forensic history. Care plans were comprehensive, up to date and included a wide range of patient information such as physical, mental and psychological health as well as skills of daily living, education and social needs. Staff completed contingency and crisis plans with patients. Care plans included patient goals that were set to support their recovery. However, on Blake ward, the pre-discharge ward, care plans lacked a recovery focus or set goals to specifically support and prepare patients for discharge back into the community.
- Staff completed a multi-disciplinary team care plan with patients with input from different disciplines. Staff reviewed care plans on a monthly basis and this was reflected in the care plans that we reviewed. Patients had a "one page about me profile" at the start of their care records which included brief information important to patients on the file, detailing, for example, things that were important to them and things which they wanted supporting people to know. This was accessible and

helped staff who may have been unfamiliar with the patients' preferences. The service used the 'my shared pathway' documentation to record patient preferences regarding their care plan and treatment.

- Staff recorded patient's physical health observations at monthly intervals. However, while staff had recorded this information in patients' records, there was no indication that staff actively followed up or monitored identified physical health needs. An example of this was a patient with diabetes. Following a complaint of dizziness and breathlessness, staff took the vital signs of the patient during physical observation that gave a blood oxygen saturation reading of 84% to 90%. Oxygen saturation measures how much oxygen is in the blood and a reading of 95% is considered normal for adults. A reading below 92% is considered low and is an indicator of poor cardiovascular health, which means that oxygen possibly may not be reaching organs and tissues to function properly. Staff had not escalated this clinical observation of low oxygen saturation levels for an urgent medical review by a doctor or supported the patient to attend hospital to seek medical assessment. Therefore, patients were at risk as staff were not appropriately following up or monitoring their physical health.
- During this inspection we reviewed the medicine charts of 21 patients. Three of the 21 patients had a total antipsychotic dose above the recommended British National Formulary (BNF) limit. Each patient record had a clear rationale for why the patient was prescribed a dose above the recommended BNF limit. On Hardy ward, one patient was prescribed a dose 200% above BNF recommended dosage and another at 150% above the recommended dosage. On Blake ward, one patient was prescribed 100% above the recommended dosage of antipsychotic medication. High dose prescribing increases the risk of adverse side effects including cardiovascular problems, ventricular tachycardia and sudden death. During our review of the medicine charts, we observed that staff did not routinely complete physical health checks and observations for these patients who were at risk of developing physical health problems as a result of high dose antipsychotic treatment. The service medication administration and management policy did include brief guidance for the monitoring of patients prescribed high dose antipsychotic treatment. However, the policy did not include specific guidance on the frequency of physical health monitoring, what physical health checks were required or clear explanation of the roles and responsibilities of medical and nursing staff in the monitoring of high dose prescribing. Therefore, staff were not effectively assessing and monitoring the physical health and the wellbeing of patients when prescribed high doses of antipsychotic treatment.
- Seven of the patients' medicine records we reviewed included patients who were prescribed Clozapine. For two of these records, there was no information about the management and side effects of the medicine. All seven of the care records we reviewed for patients prescribed clozapine did not include a care plan to assess and monitor the potential side effects of constipation which is a common side effect of clozapine treatment. We spoke to staff about how they would assess and monitor the side effects of constipation. Staff told us that patients would inform them if they were constipated. However, staff were not proactive in reviewing if patients were constipated and were not informing patients that it is a common side effect. It is important that constipation is recognised and actively managed in care planning, as clozapine has been associated with potential serious health problems if not effectively identified and managed.
- Olanzapine intramuscular depot injection was prescribed to a patient on Hardy ward. Staff had not attached the physical health observation chart to the prescription chart at the time of administration and staff had not taken physical observations after administering the Olanzapine depot injections as is required in the product specification. The product specification stated that after each injection, qualified personnel should observe patients for at least three hours for signs and symptoms consistent with olanzapine overdose. This meant that staff were not completing post administration observations to monitor for the potential side effects of olanzapine overdose including sedation, delirium, ataxia, extrapyramidal side effects, dizziness, hypotension and convulsions. This lack of monitoring meant there was a risk that staff were not monitoring and observing potential side effects and responding to them promptly.
- Staff held and completed care records on paper. The documents were stored securely in folders that were accessible to staff.

Best practice in treatment and care

Requires improvement

Forensic inpatient/secure wards

- The service had good levels of psychological input for patients and employed a full time psychologist and assistant psychologist. The psychologist had a flexible and creative approach to engaging with patients and carried out goals assessment's and reviewed patients past history of therapeutic engagement to ensure the required level of psychological input. The psychologist ran individual psychology sessions with patients and worked with staff to address the needs of patients. The psychologist also assessed patients with the substance abuse subtle screening inventory which was a self completion tool in regards to substance misuse. This was designed to distinguish between dependent and non-dependent alcohol and substance misuse.
- The psychologist ran multiple therapy groups for patients, tailored to the needs and abilities of patients in the hospital. Examples of groups included walk and talk sessions as well as yoga therapy, posture and movement groups and mindfulness. The psychologist developed a group known as 'Bobby's ward round'. This ward round was a role play exercise where the patients' ran the ward round as various members of the multi-disciplinary team about a fictitious patient. The psychologist ran this group as a way for patients to discuss their feelings gain insight into their mental health needs and encourage involvement. This was positive practice as it empowered patients to learn planning skills, identify strengths and and begin to forward plan their discharge.
- The provider had a physical health nurse who attended the service three times a week. The service registered patients with a local general practitioner who provided input into the hospital and visited once a week and recorded their physical health examinations. The service had input from a dietitian from the local authority who supported patients with their dietary needs.
- Staff participated in a number of clinical audits across the ward. Areas of clinical audit included clinical notes, care plans and risk assessments.
- Staff within the service used the health of the nation outcome scale to record patients' needs and progress through their care and treatment.

Skilled staff to deliver care

- A strong multi-disciplinary team worked across the hospital that included medical and nursing staff including one nurse who led on physical health, an occupational therapist, a psychologist, a psychology assistant, an activities coordinator, a social worker and a Mental Health Act Administrator. The service employed an external pharmacy organisation to provide a pharmacy service.
- Staff we spoke with told us that they had received an induction and health care assistants had the opportunity to complete the Care Certificate. The Care Certificate equips and supports health and social care support workers with skills and knowledge to provide safe and compassionate care.
- Supervision records we looked at demonstrated that since December 2016, regular supervision had dropped significantly. From April 2016 to November 2016, 98% of staff had received supervision. However for January 2017, 68% of staff received supervision, for February 2017 57% received supervision and for March 2017 54% received supervision. Two members of staff told us that supervision had not been consistent or regular and felt the absence of a permanent hospital director had contributed to this.
- At the time of the inspection, 89% of staff had received an appraisal. This was above the provider's target of 80%.
- Staff we spoke with felt there were limited opportunities for specialist training. Staff we spoke with did not have specific training in physical health or supporting patients with diabetes. However the interim hospital manager had recognised the service had a number of patients with borderline learning disabilities and had begun the process to seek out courses to train staff in care planning for patients with these needs.

Multi-disciplinary and inter-agency team work

- The service held weekly multidisciplinary ward rounds for patients. The consultant psychiatrist, psychologist, nurses, occupational therapists and social workers attended this meeting. Patient records and minutes of the ward rounds highlighted feedback and actions required. We attended a ward round and observed that staff covered all areas of care planning, including risk, leave, and physical health.
- Handover meetings happened twice a day during the change in shifts. Three staff members who were on the outgoing staff group, met with three of the incoming staff. Staff recorded information from handovers so additional staff could be aware of information about patient care.

Requires improvement

Forensic inpatient/secure wards

- Patients had regular six and -12 month care plan approach meetings where staff reviewed their care and treatment. The service invited patient's care coordinators to attend along with probation services and staff liaised with the criminal justice system.
- Staff we spoke with felt they had a good relationship with NHS England and the NHS trusts they received referrals from. At the time of the inspection the consultant psychiatrist was responsible for referral management but there were plans to expand this to other members of the team.
- Staff we spoke with felt they had a good relationship with the police who attended the service when requested. The provider had a patient go absent without leave recently and staff were positive about the responsiveness of the police.

Adherence to the MHA and the MHA Code of Practice

- The service had a Mental Health Act office and a Mental Health Act administrator who reviewed Mental Health Act documentation. The Mental Health Act administrator completed audits of patient MHA documentation and kept the results of the audits in patient care records.
- At the previous inspection, we identified that the provider should ensure that staff keep for each patient, accurate records of their status under the Mental Health Act, their personal details and the medicines being prescribed. At this current inspection, we identified that the service kept Mental Health Act documentation on patients' files on the ward as well as in the Mental Health Act office. This meant that staff had access to information regarding patients' detention. The records we checked displayed that staff completed paperwork appropriately. For patients detained under hospital orders of the MHA, patient care records included the annual statutory report to the Ministry of Justice.
- At the previous inspection, we identified that the provider should ensure that where patients have not understood their rights under the MHA this is revisited with patients in a timely manner. At this current inspection, we identified that staff explained to patients their section 132 rights under the Mental Health Act on a monthly basis and the service logged when staff give patients information about their rights. This information was available in easy read. However, there was no record in the care plan of one patient who staff told us needed to have information provided in easy read form to indicate that this was a specific need. Additionally, we discovered through our review of a patient's care records that a non-clinical member of staff provided translation for ward rounds and the patient's rights for four months. In the patient's record it was unclear who read the rights and staff had ticked neither box to indicate if the patient had understood their rights or not. This meant that there was a risk that staff may make assumptions that the patient had levels of understanding without ensuring their communication needs.
- Staff were not adhering to the legal conditions of section 62 forms, which is an urgent treatment form for when patients did not consent to treatment. Section 62 forms are valid for seven days, however on Hardy ward, there was one patient who had been administered medicines under a section 62 for 15 days. Staff had prescribed another patient medicines against his wishes on one occasion without a second opinion doctor to support this prescription. This meant that staff administered medicines to patients against their wishes and had not complete the necessary applications for ongoing consent to treatment assessment under the Mental Health Act.
- Staff had attached forms, which document patient's consent to treatment, to patient's drug charts. Staff completed capacity to consent to care and treatment forms where appropriate. We looked at two forms where staff recorded capacity and the rationale by the responsible clinician of the outcome.
- Patients had access to an Independent Mental Health Act Advocate. An independent mental health advocate visited the service once a month. The service displayed posters in communal areas of the advocates contact details. We spoke to patients' who said they knew who the advocate was and received support from them.

Good practice in applying the MCA

- Staff demonstrated an understanding of the principles of the Mental Capacity Act. We looked at patient's records and staff had recorded assessments of capacity appropriately.

Are forensic inpatient/secure wards caring?

Requires improvement

Forensic inpatient/secure wards

Requires improvement

Kindness, dignity, respect and support

- Throughout our inspection we observed positive interactions between staff and patients. For example, we saw that staff supported patients with their meals and interacted in a respectful manner. Staff provided care to patients in a responsive way and spoke with them in an interested manner.
- We spoke with 11 patients during our inspection. The majority of patients we spoke with felt safe and that staff were respectful and polite. Patients told us that they enjoyed the activities provided and felt that staff respected them. However, two patients told us that they did not consistently have opportunities to meet with their named nurse due to the rota system which meant that nurses worked across different wards. One patient told us that their named nurse did not work full time so they did not always have the opportunity to meet with them. Three patients said that they were not confident about the support they were receiving for their physical health.

The involvement of people in the care they receive

- Patients told us that they were given information about the service when they were first admitted. Staff orientated patients to the ward and gave information about their treatment and their rights.
- At the previous inspection, we identified that the provider should ensure that patients are involved in the development and review of their care plan and where this is not possible, the reasons for this should be recorded. At this current inspection we found that patients had a copy of their care plan and were involved in developing their risk assessments and gave their views on their current risk presentation. However the care plans contained little recorded evidence of patient involvement. For example, five of the care plans we checked on Browning ward stated that patients had declined to participate in care planning. There was no indication that staff had attempted different methods to encourage participation in care planning, including where staff had identified possible borderline learning disabilities.
- An advocate attended the hospital on a monthly basis and on demand. Patients we spoke with were aware of the advocate and knew how to contact them.
- Patients had their family for support during their Care Programme Approach meetings.
- Patients had weekly community meetings. At these meetings, staff gave patients updates about therapeutic activities during the week, maintenance issues, housekeeping and menu suggestions. Staff recorded patient's views in the minutes of these meetings and added these to the following meetings agendas as an action point. The majority of actions related to maintenance, most of which the service addressed in a quick manner.
- The service conducted a patient satisfaction survey, the most recent in January 2017. The service asked patients for their views on their care and treatment, understanding their mental health, improving the service, feeling safe and being supported to stay in contact with family and friends. For January 2017, 71% of patients gave responses. The two highest responses to questions related to "having hope" and "feeling good about myself". The two lowest responses related to "being a part of improving the service" and "my shared pathway".

Are forensic inpatient/secure wards responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access and discharge

- NHS England or local clinical commissioning groups referred patients to the service. The service assessed patients before admission. The majority of referrals were from within the local borough but the service also accepted referrals from elsewhere across England.
- From October 2016 to the end of March 2017 the service had nine new admissions. At the time of our inspection, patients occupied 21 out of 22 beds. From October 2016 to the end of March 2017 the average occupancy level across the three wards was 88%. Occupancy dropped to a low of 14 due to referrals in December 2016 but had risen in the last two months and the service currently had one patient on their waiting list.

- Where patients had been granted leave, a bed was always available on their return. Patients were not moved between wards during an admission episode unless this was justified on clinical grounds.
- The service did not have a target or timescale to discharge patients and felt the length of stay was specific to each patient. The average length of stay for patients at the time of the inspection was 622 days. 11 patients had a length of stay that was over nine months.
- From October 2016 to the end of March 2017, the service discharged six patients. The service had a low rate of delayed discharges and had one in the last six months. When facilitating a patient's discharge, the service agreed timescales and appropriate times with external parties as well as the patient. Staff held discharge meetings prior to discharge.

The facilities promote recovery, comfort, dignity and confidentiality

- The service had a full range of rooms and equipment to support treatment and care. Each ward had a communal lounge and dining area. There were patient lounges which had a TV and board games available. Patients had access to a pool room on Browning Ward every afternoon and evening and patients played pool with staff daily. For fitness, patients had access to a running machine and exercise bicycle. Wards had a clinic room which staff used for patient examinations.
- At the previous inspection, we identified that the provider should ensure that patients are able to access the self-catering kitchen regularly in order that they can practice their self-care skills in preparation for discharge. At this current inspection, we identified that patients had access to the kitchen under supervision from the occupational therapist.
- Staff supported patients to wash their laundry. There was one laundry room based on Blake ward. The service had a laundry rota in use which indicated when staff would support each patient to do their laundry during the week.
- At the previous inspection, we identified a concern where patients who did not have access to leave, asked members of staff to withdraw money from cash machines for them by giving them their pin numbers. This meant that there was a risk that patients could be subject to financial abuse and that staff may be at risk of allegations being made about them. At this current inspection, we identified that the service had recently taken action to withdraw money from the hospital's finances on behalf of patients who did not have access to leave. However, we spoke with staff and they were not sure about how patients would pay this money back. This meant that the system for managing finances for patients, who were not able to access leave, remained unclear.
- The service had a visitor's room off the wards which patients' could use for privacy when meeting with friends or family.
- The service had previously restricted children from visiting patients at the building. However the new interim hospital director had recently reversed this policy and there was a visitors room at the entrance where children could visit, and plans were in place to make the visiting area more child friendly.
- Patients did not have access to their own mobile phones when they were on the ward, but could retrieve them from reception when they went on leave. Patients could use the pay phone and a calling card, which they added money to when they went on leave. The service informed us they had plans to purchase mobile phones for patients to contact carers and friends in the privacy of their own rooms.
- A garden was located on the ground floor which all patients could access with staff. The garden environment was pleasant and patients had restricted access to the hospital garden with 15 minute breaks at 9.30am, 1.30pm and 5.45pm. Patients were able to access leave between 9.15am and 5pm.
- Staff accompanied patients downstairs to eat in a canteen shared by other patients in the hospital. Patients had a choice of meals. There was one meat and one vegetarian option. Staff said they would cater for individual needs and in the past catered for halal and Caribbean dietary needs. The majority of patients we spoke with felt the food was good, however one patient said they served chicken most days and would like more varied options.
- Patients were able to have hot drinks and snacks in the lounge. Staff replenished hot drinks throughout the day and the communal lounge had a drinks machine which patients could use to get a hot drink at any time of day or night.
- Patients were able to personalise their bedrooms if they wished and could have a stereo and a TV in their bedrooms.

- The multi-disciplinary team ran a full programme of therapy and groups during the day. Patients on the ward had access to a large range of activities including cooking sessions, Tai chi and mindfulness. In addition to this, patients had access to a community gardening project and had art and music sessions in the local community. Some patients regularly visited a local gym. The service had a recovery college project which offered training for patients and staff such as courses in mindfulness and an exercise group.The service offered all patients 25 hours of meaningful activity as per the key performance indicator target. However, not all patients had chosen to take up all of the activities offered. Despite this, we observed that each patient had their own weekly activity schedule which was on the electronic care records. From this it was possible to see whether patients attended their activities, refused to attend, had a conflicting appointment, or were unwell at the time of the activity. This meant that staff could assess the patients' engagement in therapeutic activities over time and demonstrated that patients were able to access activities. However, there were no activities that provided employment opportunities to patients.

Meeting the needs of all people who use the service

- The service had a lift that went to all wards which mean the service could accommodate patients with reduced mobility. There was an accessible bedroom with en suite facilities on the ground floor.
- There was information displayed on wards and across the hospital relating to local services, patients' rights and how to complain. However the service had one patient who did not speak English as a first language and the leaflets were not available in languages other than English.
- The provider demonstrated difficulties in getting an interpreter for a patient on Browning ward who did not speak English as a first language and had some communication difficulties. During our review of this patients care record we saw evidence in the progress notes that a non-clinical member of staff at the service had interpreted medical reviews, psychology sessions and section 132 rights. The non-clinical member of staff who had been assisting with interpreting and communication did not have a formal qualification in interpreting. Staff also used google translate to feedback information. The patient had a care plan in place called 'barriers to effective communication' which stated that an interpreter will be required for clinical meetings, but this was not happening. Staff had signed the care plan stating the patient was 'unable to sign the care plan due to language issues'. Minutes of ward rounds the patient was involved in noted that the patient needed a translator. However the service had not taken any actions to address this issue. We asked staff on the ward if they were aware of an interpreter attending ward rounds and one to one meetings with the patient. Staff told us that they used an interpreter when they took the patient to hospital appointments but that it was not usual practice to engage an interpreter for ward rounds.
- The service had identified two patients as possibly having a borderline learning disability on Browning ward. Staff on the ward told us they had not had access to specific training related to learning disabilities and autism. However, they told us that the service had planned additional training to support staff working with patients with specific communication needs. We checked the records of these patients and did not see that staff had identified specific needs relating to communication in care plans. This meant that there was a risk that staff had not met the specific needs of these patients. For patients with limited insight and verbal communication, care plans were not adapted to easy read. This meant that there was a risk that communication was not as robust as it might have been and that there was a risk that key information was not being passed between staff and patients.
- There was a lack of spiritual support offered to patients. There was no multi faith room set aside at the service for spiritual support. A patient we spoke with said they prayed in their room. The social worker was responsible for arranging the spiritual needs of patients. We also found during our review of care plans that the diversity section was not personalised, simply stating facilitate further exploration of spirituality and further cultural needs if required.

Listening to and learning from concerns and complaints

- At the previous inspection , we identified the provider should ensure that information about its complaints procedure is displayed around the hospital and that all complaint investigation records are stored together in

the format prescribed by their complaints policy and procedure. At this current inspection we identified that the provider clearly displayed information about how to complain on the wards. However when we asked staff for the complaints investigation records, they had difficulty in accessing this. When we did receive a complaints folder it did not have any evidence of whether the provider investigated the complaint or the outcome of the complaint. From April 2016 to April 2017 the provider received 441 complaints. 439 of these complaints had come from one patient. When we asked staff about this they told us that they dealt with the complaints on an informal basis at the fortnightly ward rounds. When we asked staff for records of the two other complaints, they were unable to access historical logs of complaints and could not find a system that documented recorded complaints. As a result we were unable to determine what the complaints were and the outcome of them.

- Patients we spoke with told us that they were aware of how to complain and felt comfortable raising complaints with staff.

Are forensic inpatient/secure wards well-led?

Requires improvement

Vision and values

- Staff were aware of the visions and values of the provider. The interim hospital director felt that the visions and values of the provider should be promoted more, for example when recruiting staff.
- At the previous inspection, we identified that the provider should ensure that senior managers at a corporate level have a presence within the hospital and understand the demands of providing care and treatment. At this current inspection, we identified that the majority of staff we spoke with were aware of who senior managers were within the provider. However most staff did not feel they were visible. Three members of staff told us that they did not feel engaged with the organisation as a whole. While there had been recent visits from senior staff within the provider to the wards, they did not feel the organisational vision was well-established within the hospital. One member of staff told us that while they see the hospital director, they do not feel engaged with the wider organisation.

Good governance

- At the time of this inspection a full time interim hospital manager had been in post for a week. The previous hospital director had not been working at the service since December 2016. A hospital director from one of the provider's other locations had covered the hospital director position at Battersea Bridge House from January 2017 to April 2017.
- At the time of our inspection the service was going through a period of change. The previous hospital director had been replaced following an investigation and the provider had acted promptly to arrange an interim hospital director.
- Although the provider had established governance structures these had not operated effectively in the hospital over the past 12 months. The absence of a permanent hospital director for four months meant that the hospital had experienced a temporary lack of leadership. Senior directors were supporting the interim hospital director in the day to day operations of the hospital.
- The hospital had access to data that monitored supervision, training, appraisals and incidents. The hospital submitted a weekly operations report to the director of operations. . This report reviewed occupancy levels, staffing, sickness and incidents. The service also monitored key performance indicators including average length of stay, training and delayed transfers of care. The hospital director submitted a report prior to the monthly governance meeting with senior directors that included a narrative of safeguarding, complaints, compliments, training and incident reporting. However, senior directors had limited insight into how the service collated information and were unaware of how trends were analysed or disseminated throughout the organisation.
- During this inspection we had difficulties in accessing information relating to governance. When we spoke with senior directors about accessing information, they

were unsure how staff reported incidents and how these were actioned and followed up. There was no accessible information on trends or themes of incidents in the hospital.

- The hospital did not have an accurate record of complaints that detailed the outcomes of the complaints and any improvements that had taken place.
- The hospital director was responsible for feeding back the outcomes from corporate governance meetings to ensure they embedded lessons and actions at the hospital. Despite this, staff did not have the opportunity to learn from incidents across other locations. We reviewed minutes of recent operations meetings and did not see evidence of learning from incidents. Staff we spoke with confirmed this.
- At the previous inspection, we identified that the provider should ensure that the hospital manager has sufficient authority to carry out their role, including management of a local budget for maintenance and improvement of the environment in a timely manner. At this current inspection, we identified that the interim hospital director had control of the budget for maintenance and improvement of the environment was on-going.
- The interim hospital director was aware of the governance issues we discussed and had plans to ensure the governance of the hospital was more robust. The interim hospital manager wished to review restrictive practices and wanted to make processes more clear, focused and based around risk management planning. The interim hospital director felt supported by both senior managers and staff within the service.
- There was a service specific risk register and local risk register issues were discussed in the corporate quality governance meeting though it was the responsibility of each local hospital director to keep their risk register up to date. At the time of the inspection, the service had last updated the risk register in November 2016. We spoke with the interim hospital director who was aware of this and planned to update the register. The interim hospital director highlighted the main risks at the service as staffing, environmental aspects including ligature work, increasing use of bank and agency staff and work life balance for staff.

Leadership, morale and staff engagement

- Many of the staff we spoke with told us that morale was generally good in the hospital and had improved over the previous three months. Staff said that there had previously been a culture of intimidation and fear in the hospital. They said there was previously bullying from management and that they were afraid to speak up. The provider had acted promptly to address the concerns which staff had raised during a whistleblowing process. Overall, staff felt well supported.
- Staff said that they now felt confident to speak up or use the whistle blowing service.
- Staff we spoke with said that they had a good work life balance and that it was not difficult to arrange and swap shifts with other staff if needed. Staff said that they enjoyed working in the team. Agency staff said that they always felt welcomed by the other staff members and this made them want to come back to work in this hospital.
- Nurses had the opportunity to train as mentors. However, staff told us that other than this, the provider did not promote leadership training within the organisation.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that medicines are safely stored at the correct temperatures
- The provider must ensure that patients prescribed high dose antipsychotics have physical health monitored according to guidance.
- The provider must ensure that staff proactively assess and provide care planning for potential side effects of constipation with clozapine treatment.
- The provider must ensure that staff have access to emergency medicine without delay.
- The provider must ensure that there is an effective and cohesive system to record incidents.
- The provider must continue to complete work to remove ligature risks and address the continuing faults of the airlock system in reception.
- The provider must ensure that there are sufficient levels of qualified and experienced staff on each shift in line with the hospitals minimum stated staffing levels. The provider must also ensure patients have regular 1:1 sessions with their named key-worker.
- The provider must ensure that nursing and medical reviews of patients in seclusion are carried out and recorded comprehensively.
- The provider must ensure there is effective learning from incidents.
- The provider must ensure patients are able to close viewing panels in their bedrooms.
- The provider must ensure that patient's physical health concerns are actively monitored and followed up by staff.
- The provider must ensure that patients are involved in the development of their care plans and where this is not possible, the reasons recorded.
- The provider must ensure that staff receive regular supervision
- The provider must ensure it meets the needs of patients who require translation from English to another language including access to interpreters and other written information.
- The provider must ensure that investigations of complaints are recorded and stored in an accessible format.
- The provider must ensure there are robust systems to monitor the safety and performance of the hospital.

Action the provider SHOULD take to improve

- The provider should ensure that risk assessments are updated following incidents.
- The provider should ensure that staff follow and monitor safeguarding referrals and concerns.
- The provider must ensure consent to treatment forms for patients are in date and completed.
- The provider should ensure that care planning for patients with borderline learning disabilities includes a focus on communication needs of the patient.
- The provider should ensure care plans on the pre discharge ward are recovery focussed and include goals to prepare patients for discharge in to the community.
- The provider should ensure staff adapt to patient's specific communication needs when informing them of their rights.
- The provider should ensure the arrangements for patients to access money when they are going on leave are operating robustly.
- The provider should ensure they develop employment opportunities for patients.
- The provider should ensure patients are supported with their cultural and spiritual needs.
- The provider should ensure senior managers at a corporate level are visible and have a presence at the hospital.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider did not design care or treatment with a view to achieving service user's preference and ensuring their needs are met. The provider did not organise a qualified translator to translate for a patient whose first language was not English and had minimal spoken English. **This was a breach of regulation 9 (3)(b)** The provider did not enable and support relevant persons to make, or participate in making, decisions relating to the service user's care or treatment to the maximum extent possible. Patients were not involved in the development of their care plan. Staff did not record reasons for this. **This was a breach of regulation 9 (3)(d)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure that care and treatment was being provided in a safe way for service users. The provider was not assessing the risk to the health and safety of the patients. Staff did not take effective or prompt action to respond to patients' physical health needs and concerns Staff did monitor patients who were placed in seclusion in accordance with the guidance outlined in the Mental Health Act code of practice.

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 12 (2) (a) (b)

The provider did not ensure they did all that is reasonably practicable to mitigate risk. They should follow good practice and must adopt control measures to make sure the risk is as low as is reasonably possible.

Patients were unable to close viewing panels in their bedroom doors.

This was a breach of regulation 12 (1) (2) (b)

The provider did not ensure there are sufficient quantities of medicines to ensure the safety of service users and meet there needs.

Emergency medicines were stored on one ward only which meant staff had to move between doors and separate floors to obtain emergency medicines if needed.

This was a breach of regulation 12 (1) (2)(f)

Regulated activity	Regulation
	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

The provider did not ensure that all premises and equipment used by the provider was secure, suitable for the purposes for which they are being used and properly maintained.

At the previous inspection, the hospitals ligature risk assessment identified a range of ligature points throughout the hospital that required replacement. At this current inspection, we identified that further work was required to reduce the number of ligature points and this was a continuation of this breach.

The airlock system in the reception area was not always secure and the door did not always lock shut**.**

This was a breach of regulation 15 (1) (b) (c) (e)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider did not ensure that complaints were investigated and that necessary and appropriate action was taken in response to any failure identified by the complaint or investigation Records of complaints were not stored in an accessible format prescribed by the provider's complaints policy and procedure. **This was a breach of regulation 16 (1) (2)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not ensure that systems or processes were established and operated effectively to ensure compliance. The systems or processes did not enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. The provider did not have an effective system to record incidents. The provide did not have embedded systems for staff to learn and share learning from incidents in the hospital and thereby prevent or reduce chances of reoccurrence **This was a breach of regulation 17 (1)(2)(a)(b)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

The provider did not ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons were always deployed in order to meet the requirements of this regulation.

Wards did not have sufficient levels of qualified and experienced staff on each shift and patients were not having regular 1:1 sessions with their named worker.

This was a breach of regulation 18(1)

The provider did not ensure that persons employed by the service provider in the provision of a regulated activity received appropriate supervision as is necessary to enable them to carry out the duties they are employed to perform.

Staff did not receive regular supervision.

This was a breach of regulation 18 (1) (2) (a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure that care and treatment was being provided in a safe way for service users. The provider was not assessing the risks to the health and safety of the patients. Patients who were prescribed high dose antipsychotics did not receive regular physical health monitoring. Potential side effects of clozapine treatment, including constipation, were not robustly assessed and monitored **This was a breach of regulation 12 (2) (a) (b)** Medicines were not stored at the correct temperatures and checks of fridge temperature were not being completed. **This was a breach of regulation 12 (1) (2) (g)**